Healthcare Reform Implementation: Moving Forward and Managing Change

Joey Wynn,
Co Chair – Florida HIV AIDS Advocacy Network
November 14th, 2012
PCPG meeting / Tampa, Florida
Background:
Budget decisions affect HIV/AIDS programs

Federal $$
- HIV prevention & testing (CDC)
- Ryan White programs, including ADAP (HRSA)
- Substance abuse & mental health (SAMHSA)
- Housing for persons living with AIDS (HOPWA)
- HIV/AIDS research (NIH)
Background:
Budget decisions also affect other services

Federal $$ also pay for other programs that are important to people living with HIV/AIDS

- Medicaid & Medicare
- Community health centers
- Planned Parenthood (including testing)
The Supreme Court Decision: In Brief

• Upheld requirement to purchase insurance ("individual mandate")
  – Exchanges, new insurer rules, etc. move forward

• Found Medicaid expansion "coercive"
  – States can opt out of the Medicaid expansion without risking all of their federal Medicaid $

• Left other provisions in intact - applies only to authority to enforce Medicaid expansion
The Impact of the Decision: Estimated Coverage in 2022

In Millions

ACA Implementation Looks Different In Every State

- ACA Statute
- Federal Regulations or Guidance
- State Flexibility
Burning Issues

• Medicaid Expansion
• Essential Health Benefits
• State Exchanges
Medicaid Expansion Update

• CBO lowered enrollment estimate by 6 million

• No deadline for states to opt in

• 100% federal match applies 2014 to 2016

• States required to maintain eligibility for enhanced rates ("MOE requirement")

• States may push for partial expansion

• Many states will wait...until after the elections
Medicaid Expansion: Estimated Increase in Enrollment by State

2.0% - 21.7%
25.2% - 32.4%
32.9% - 40.0%
40.4% - 61.7%

Medicaid Expansion to 133% of Federal Poverty Level (FPL): Increase in Enrollment and Spending Relative to Baseline: Enrollment in 2019

statehealthfacts.org
Making the Expansion Work:
Medicaid Primary Care Rate Increase in 2013 & 2014

• Internists, family medicine and pediatricians and NPs/PAs they supervise eligible for enhanced rates for primary care services

• No minimum billing requirement

• Specialists trained in IM, FM, and Pediatrics including infectious diseases, eligible
Essential Health Benefits
What We Know

• States selecting from 10 benchmark options to set the standard for their EHB

• State benchmark selection were due Sept 30th

• Largest small group plan in the state is the default
  – Generally lowest cost option, more service limits, etc.

• Regulations delayed until how long after elections?
Ryan White Core Services vs. EHB

**Ryan White Core Services**

- Ambulatory and outpatient care
- AIDS pharmaceutical assistance
- Mental health services
- Substance abuse outpatient care
  - Home health care
  - Medical nutrition therapy
  - Hospice services
  - Home and community-based health services
  - Medical case management, including treatment adherence services
  - Oral health care (not standard)

**ACA “Essential Health Benefits”***

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management, and
- Pediatric services, including oral and vision care
Low Bar Set for Drug Coverage

- Plans only required to cover one drug per drug class or category (per 12/16 guidance)

- Urging stronger protections at the federal level
  - Adopt Medicare Part D classes of clinical concern (AKA – 6 protected classes)
  - Ensure coverage meets the HHS HIV treatment guidelines (www.aidsinfo.gov)

Federal comment period on state selections this fall
State-based Exchanges – Key Dates and Options

• State blueprints due mid-November

• HHS approve (or conditionally approve) by 1/1/2013 for 2014

• States may establish in 2015 and beyond
  – Grants continue through 2014

• If no state plan – exchange will be “federally facilitated” — http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf
The Role of the Exchanges: Federal Rules

- Certify “qualified health plans”

- Educate consumers
  - Must establish call center, website, navigators (at least one nonprofit group), premium calculator

- Conduct or contract eligibility and enrollment
  - Streamlined “no wrong door” application process

- Set standards for provider networks
  - Required to contract with “sufficient number and geographic distribution of essential community providers”
  - Ryan White providers identified as essential
New Preventive Services Benefits – Effective in New Plans August 2012

• HIV screening and counseling
• Well-woman visits
• Screening for gestational diabetes
• HPV testing for women 30 years and older
• STI counseling
• FDA-approved contraception methods and contraceptive counseling
• Breastfeeding support, supplies, and counseling
• Domestic violence screening and counseling
These slides were created by Amy Killelea, National Alliance of State & Territorial AIDS Directors

STATE UPDATE
Timeline


U.S. Supreme Court decision

2012 Elections
States must submit plan for exchange to HHS (choosing state-run, federal, or partnership)

HHS certifies exchanges

Open enrollment for exchange coverage

Medicaid and exchange coverage begins

States must choose Essential Health Benefits benchmark plan for private insurance plans sold through exchanges

Automatic federal cuts as a result of Budget Control Act go into effect (could impact community health centers, subsidies to purchase private insurance, Ryan White Program)

Federal regulations still to come:
- Medicaid reimbursement (final)
- Essential Health Benefits (exchanges AND Medicaid)
- PCIP transition
- Basic Health Program

Source: Treatment Access Expansion Project, May 2012
PPACA Implementation Decision Points

ACA Implementation: Decision Points

Federal
- Agencies (Dep't of Health and Human Services; Dep't of Labor; Dep't of the Treasury)
- Congress
- President

State
- Agencies (Dep't of Insurance, Dep't of Health, HIV/AIDS Office, Medicaid)
- State legislature
- Governor
- Exchange board

Source: Treatment Access Expansion Project, May 2012
What happens in a state that does not comply with expansion?

- **Traditional Medicaid**
  - Limited to people with very low income AND who fall into qualifying category:
    - Disabled
    - Low-income parents w/ dependent children
    - Pregnant women
    - Low-income children

- **The Gap**
  - People with incomes below 100% FPL, but who cannot qualify for Medicaid under current rules.
  - May be left out of reform if the state does not expand.

- **Subsidized Private Insurance through Exchanges**
  - Private insurance available through exchanges:
    - Premium tax credits for people with income between 100 and 400% FPL
    - Cost-sharing subsidies for people with income between 100 and 250% FPL

- Greater role for Ryan White Program and ADAP
- Greater dependence on subsidies to purchase private insurance
States with the Greatest Gaps in Coverage if They Do Not Comply with Medicaid Expansion

Medicaid Coverage of Low-Income Adults, January 2012

NOTE: Map identifies the broadest scope of coverage in the state.
Most States are Still Weighing Options with Regard to Medicaid Expansion and Weighing Costs/Benefits

• There are still plenty of reasons a state will continue with expansion:
  • Federal government pays 100% of expansion costs for 2014-2016 and gradually reduced to 90% in 2020 and beyond
  • Other reforms (e.g., DSH payment reductions) make it difficult not to expand because of the increased pressure on hospitals without increased revenue from insured patients
  • Uptake may be slow, but states have generally come around to Medicaid and CHIP expansions
Medicaid Reforms Still Happening in States

State Medicaid Reform Implementation Activities

- Expanded Medicaid early under ACA option (7 states and DC)
- Approved or submitted plan to update Medicaid eligibility systems (28 states and DC and includes early expansion states of DC, MN, and NJ)
- Opted not to expand early and have not yet updated Medicaid eligibility systems (17 states)

Map created using data from Kaiser Family Foundation
Predicting Client Migration

- Identifying clients who will be affected
  - Eligible for Medicaid
  - Eligible for subsidized private insurance
  - Those left out of reform (undocumented immigrants ineligible for public or private insurance expansion and legal immigrants within 5 year ban still ineligible for Medicaid)

**ADAP Clients Served, by Insurance Status, June 2011**

- Uninsured: 60%
- Private Insurance: 21%
- PCIPs: 2%
- Medicare: 15%
- Dually Eligible (Medicaid & Medicare): 6%
- Medicaid: 10%

Two-thirds (68%) of ADAP clients had income levels at or below 200% FPL.
Essential Health Benefits: Will the Private Insurance Benchmark Plan Cover Necessary Care and Treatment?

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<thead>
<tr>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
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<td>Retrovir</td>
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Not on formulary:
- Epzicom
- Darunavir/Prezista
- Aptivus

Etravirine (Intelence)
Maraviroc (Selzentry)
Raltegravir (Isentress)
Essential Health Benefits: Will the Private Insurance Benchmark Plan Cover Necessary Care and Treatment?

• Ongoing concerns:
  – Federal prescription drug requirements are weak (plans must cover only one drug in each class) and confusion among states
    • CA interpreting one drug per class language as standard rather than floor
    • NY and MA interpreting one drug per class language as floor
  – Service limits and utilization management techniques may continue
Exchange Planning: Getting to the Table

• Challenges in engaging in exchange process:
  – Finding the decision makers
  – VERY fast timeline
    • EHB benchmark must be chosen by September; blue print deadline is November
  – HIV is small piece of larger planning issues

• Successful strategies for involvement:
  – State HIV/AIDS Ryan White all parts meetings as venue to engage Medicaid and others on health reform (KY, MN, TX)
  – Coalitions with other stakeholders
Moving Forward: Planning for Role of Ryan White Program Services

- Identifying gaps in covered services and affordability
  - E.g., insurance assistance
  - E.g., support services
  - E.g., dental services

<table>
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<tr>
<th>Federal poverty level</th>
<th>Income</th>
<th>Premium contribution as a share of income</th>
<th>Out-of-pocket limits</th>
<th>Actuarial value: silver plan</th>
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<td>94%</td>
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<td>F: $92,200+</td>
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<td>F: $12,100</td>
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Source: Commonwealth Fund, 2012
Ongoing State Implementation Issues

• Outreach and enrollment programs
  – Patient Navigator program design
    • Eligibility criteria for state contracts must include those with disease specific expertise
    • Training must include range of health and social services programs (e.g. Ryan White Program)
    • Program should utilize subcontracts to smaller CBOs with expertise in reaching vulnerable populations
  – Coordination of ADAP/Ryan White Program application and eligibility determination with new systems
    • E.g., Data sharing with Medicaid, Dep’t of Insurance, and others

• Provider network adequacy standards
• Payer of last resort compliance
• Infrastructure to serve an insured population
Resources

- HIV Health Reform, http://www.hivhealthreform.org
- State Refor(u)m, http://www.statereforum.org
- KFF--State Activity Toward Creating Exchanges -- http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17
- Medicaid Expansion Advocacy Resources
  - National Health Law Program
  - Families USA
  - Treatment Access Expansion Project